Appeal Guidelines

Your appeal MUST be received within 60 *calendar* days of the denial letter for consideration.

Patient Name: _____Phone #:_____Chart #: _____

DOB: _____ Date(s) of Service: _____

Vendor (where were services received)?

_____

Total Amount Due (call the Vendor to verify balance):
$_____

Other Health Coverage:_____

INCLUDE FOLLOWING ITEMS:

___**Denial Letter**: Copy of your denial letter from Purchased/Referred Care (PRC).

___**Bills:** Medical bill that you would like considered for payment.

___**Explanation:** See below and elaborate on the reverse side:

What were the circumstances?

Why should this be considered for payment?

Has it happened before?

What was the diagnosis?

Did you call the triage line?

Were you under the influence of alcohol or drugs?

Tanana Chiefs Conference

Explanation:

Patient Experience Department

For Appeal Questions Contact: Patient Experience

patientconcerns@tananachiefs.org

Tanana Chiefs Conference